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GASTRO-INTESTINAL SYPHILIS

By J. W. McNEE, M.D., F.R.C.P., Physician to University
College Hospital.

At the present time a physician sees no primary syphilis, very little secondary syphilis, and, if I except cardiovascular and neurological diseases, not a great deal of tertiary lesions. The last case of secondary syphilis which I have seen clinically came into my wards a few years ago as a primary acute nephritis which cleared up rapidly with mild salvarsan treatment.

All physicians agree that gastro-intestinal syphilis is exceedingly rare, both to suspect clinically and to prove pathologically. If I begin at the upper end of the gastro-intestinal tract, syphilis of the *æso-phagus* must be very rare, and I have no experience of it. Syphilis of the *stomach* is of much greater clinical importance, and must be considered in various aspects. How does early syphilis affect the stomach? Nothing definite is known, but from the observations of Stoeckenius on early secondary syphilis, the stomach must presumably share in the tissue changes. It is stated that in early syphilis, achlorhydria is common, but I doubt if this has any significance. As regards the later stages of syphilis the mistake must not of course be made of regarding "gastric crises" as evidence of some form of organic gastric disease; I have seen this error made twice, and a needless operation undertaken.

True tertiary syphilis of the stomach does occur, as I shall show, and in tracing the history of our knowledge of it, the literature must be divided into observations made before the discovery of the spirochætal cause (1906) and the Wassermann reaction (1907), and those made subsequent to these discoveries.

There is only one important paper (Soltau Fenwick, *Lancet*, 1901) published in England in the earlier days. The point which interested Fenwick was whether any percentage of cases of "gastric ulcer" could be regarded as truly syphilitic in origin, and his conclusion finally

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was that 5 per cent. could be so regarded, his evidence being derived both from post-mortem examination and from the results of anti-syphilitic therapy.

In Germany there is quite a long literature on gastric syphilis, one of the most quoted of the older papers being that of the pathologist Chiari (1891). In France many doubtful cases were also recorded. In America Flexner (1898) described an absolutely typical case of gumma of the stomach.

Since 1907 the literature, especially in America, has been extensive and naturally far more exact. Gustave Monod (1922) in an "Occasional Lecture" to the Royal Society of Medicine, described more recent French observations; and, in fact, in most countries except our own quite an extensive literature of well-authenticated cases is now available for study. In Britain, very few cases have been reported, and one described by myself (*Quarterly Journal of Medicine*, 1922, XV., 215—with literature) has been much quoted in foreign journals, since it appears to be unique, in that the spirochætal cause was found abundantly in one part of the gummatous lesion of the stomach.

Since this case was reported in detail, with adequate illustrations, I need only mention the main facts quite briefly. Its discovery was an accident. A male, aged fifty-seven, was admitted to hospital complaining chiefly of pain in the chest, constipation and loss of weight. A mass about the size of a hen's egg could be easily felt in the epigastrium, and a diagnosis of gastric carcinoma was made. This appeared to be confirmed by the test meal, which showed complete achlorhydria. A severe hæmatemesis occurred, followed by a second bleeding a fortnight later. After the second attack the man collapsed, and obviously had perforated, but owing to his ill state and the diagnosis already made, no operation was considered.

In the post-mortem room various things struck me as peculiar. There was a large and extensive ulcerated mass in the stomach, with perforation at one spot, but in spite of the great extent of the supposed carcinoma, no secondaries could be found in neighbouring lymphatic glands or in the liver. To make the story quite short, the mass was found on histological examination to be a typical gumma, with well-marked endarteritis obliterans,

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and in one area very abundant spirochætes of typical form were found. Many pathologists have seen this case, and all agree that the lesion is a gumma, and that the spirochætes are typical.

Naturally if this case had been properly diagnosed at an earlier stage, anti-syphilitic treatment might have saved him. In the literature there are now a number of cases in which "lumps" have been palpable in the stomach of syphilitic patients, confirmed by X-ray deformity, which disappeared entirely under treatment with iodides. Iodides seem to be far more successful in these cases than any other form of anti-syphilitic treatment.

The question of whether there is any other form of late gastric syphilis, apart from gumma, is difficult to answer. So far I am not convinced that there is a genuine syphilitic gastritis, or a truly syphilitic round ulcer. A gumma of the stomach may be small, localised and (as in recorded cases) adherent to the liver. When such a gumma breaks down, it may obviously simulate a chronic penetrating gastric ulcer.

So far as I am aware syphilis of the *small intestine* has never been described. In the *colon*, gummata have been met with, and in a case of neurological syphilis in my own experience a large mass involving the colon disappeared rapidly under anti-syphilitic treatment.

Syphilis of the *rectum* is far better known to specialists on venereal disease than to physicians, so I will say nothing about it.

I wish to extend the subject for a moment to include syphilis of the liver. Nowadays hepatic syphilis *in adults* is rare, and gummata are seldom seen even in the post-mortem room. In fact I believe I now see far more damage to the liver from anti-syphilitic treatment than from syphilis itself, and am at times alarmed at the intensity of arsenical and other treatment now employed.

These remarks cover all that I can usefully say about gastro-intestinal syphilis. Gummatous lesions certainly occur in the stomach and colon, and are well-proven. Much of the rest is far too speculative, depending on the cure of symptoms in the gastro-intestinal tract in patients, known to be syphilitic, and actively treated.